Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF DALLAS
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-11-0108-02

MFDR Date Received
September 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $3,215.22 for APC # 0042. Allowing this at 200% would yield a fair and reasonable allowance of $6,430.44. Also, Medicare would have reimbursed the provider at the base APC rate of $3,215.22 for APC # 0042. Allowing this at 200% would yield a fair and reasonable allowance of $6,430.44, but per the multiply procedure rule the correct allowable would be at 50%, making the correct allowable $3,215.22. And again Medicare would have reimbursed the provider at the base APC rate of $3,215.22 for APC # 0042. Allowing this at 200% would yield a fair and reasonable allowance of $6,430.44, but per the multiply procedure rule the correct allowable would be at 50%, making the correct allowable $3,215.22. And again, Medicare would have reimbursed the provider at the base APC rate of $1,921.67 for APC # 0041. Allowing this at 200% would yield a fair and reasonable allowance of $3,843.37, but per the multiply procedure rule the correct allowable would be at 50%, making the correct allowable $1,921.67. As you can see the charges for all the OR services were bundled into on charge line on the UB, but that does not meant that all these lines should not be reimbursed, as they should all pay per the APC allowable per the fee schedule. For all of the APC allowable the amount due totaled is $14,782.55. Based on their payment of $6,430.44 for the APC a supplemental payment is still due of $8,352.11 on the APC alone, at this time."

Amount in Dispute: $8,424.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "PREVIOUS PAYMENT TO PROVIDER OF $11751.70 CORRECTLY CALCULATED ON BASIS OF DOCUMENTATION, MEDICARE APC VALUES, TDI/DWC 200% CALCULATION METHODOLOGY, & NCCI EDITS . . . CARRIER DISAGREES WITH HRA ALLEGATION THAT CERTAIN LINES OR APC'S WERE NOT PAID, DUE TO BEING BUNDLED ON ONE CHARGE LINE ON THE UB . . . CPT 29823 APC 0042 CORRECTLY DENIED FOR PAYMENT ON BASIS OF NCCI OUTPATIENT HOSPITAL CODE EDITS . . . THE PAID APC VALUES ARE IN EXACT ACCORDANCE WITH HRA CALCULATIONS . . . PAYMENT OF $11751.70 WAS ISSUED TO PROVIDER (NOT HRA'S STATED AMOUNT OF $6430.44) . . . CARRIER HAS RESPONDED TO & EVALUATED EVERY APPEAL SUBMITTED."

Response Submitted by: Claims Management, Inc., PO Box 1288, Bentonville, AR 72712-1288

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due

September 9, 2009 to September 10, 2009	Outpatient Hospital Services	$8,424.11	$121.04

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 219 – BASED ON EXTENT OF INJURY.
   - 899 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR) COMPONENT CODES OF COMPREHENSIVE SURGERY: MUSCULOSKELETAL SYSTEM PROCEDURE (20000-29999) HAS BEEN DISALLOWED.
   - 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM. UR/JE
   - 5073 – CHARGE UNRELATED TO THE COMPENSABLE INJURY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS MULTIPLE PROCEDURE RULE.
   - 1001 – BASED ON THE CORRECT BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
   - 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER, BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
   - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 10 – THE BILLED SERVICE REQUIRES THE USE OF A MODIFIER CODE.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per

§134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code L3670 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $97.27. 125% of this amount is $121.59. The recommended payment is $121.59.

   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

   - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $12.36. 125% of this amount is $15.45. The recommended payment is $15.45.

   - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.

   - Procedure code 29807 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,914.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,215.22. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.289. This ratio multiplied by the billed charge of $8,361.75 yields a cost of $2,416.55. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,215.22 divided by the sum of all APC payments is 55.59%. The sum of all packaged costs is $2,563.88. The allocated portion of packaged costs is $1,425.25. This amount added to the service cost yields a total cost of $3,841.80. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $3,215.22. This amount multiplied by 200% yields a MAR of $6,430.44.

   - Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,914.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The

sum of the labor and non-labor related amounts is $3,215.22. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,607.61. This amount multiplied by 200% yields a MAR of $3,215.22.

- Per Medicare policy, procedure code 29823 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,144.42. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,921.67. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $960.84. This amount multiplied by 200% yields a MAR of $1,921.68.
- Procedure code 97003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $74.95. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division conversion factor of 53.68 yields a MAR of $111.55. The recommended payment is $111.55.
- Procedure code 97110 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $28.37. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division conversion factor of 53.68 yields a MAR of $42.22. The recommended payment is $42.22.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. This service is classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.12. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $0.12. The non-labor related portion is 40% of the APC rate or $0.08. The sum of the labor and non-labor related amounts is $0.20. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $0.20. This amount multiplied by 200% yields a MAR of $0.40.
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. The total recommended payment for the services in dispute is $11,872.74. This amount less the amount

previously paid by the insurance carrier of $11,751.70 leaves an amount due to the requestor of $121.04.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $121.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $121.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 30, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.